CLINICAL MEDICINE

VOL. 57 JUNE, 1950 NO. 6

Original Articles

Editorials

He's heard the call for

VI-DAYLIN

TRADE MARK

(Homogenized Mixture of Vitamins A, D, B_1, B_2, C and Nicotinamide, Abbott

For spoon-licking acceptance at vitamin time, there is nothing quite like Vi-Daylin—the honey-yellow liquid with the delicious citrus-like flavor and odor. Each 5-cc. teaspoonful, the average daily dose for children up to age 12, contains six essential vitamins, as shown in the formula. It's good direct from the spoon, or mixes readily with baby's formula, fruit juice or cereal. Lots of older folks take Vi-Daylin, too, rather than bother with hard-t swallow capsules, tablets, or bitter-tasting preparations. It remains stable without refrigeration, has no fishy odor. Prescript pharmacies stock Vi-Daylin in three convenient sizes: 90-cc., 8-fluidounce and 1-pint bottles.

Each 5-cc. teaspoonful of Vi-Daylin contains:

Vitamin A	3000 U.S.P. units
Vitamin D	800 U.S.P. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Ascorbic Acid	40 mg.
Nicotinamide	10 mg.

Abbot

CLINICAL MEDICINE

ESTABLISHED 1894

A Journal Devoted to the Advancement of General Practice

Published Monthly by the
AMERICAN JOURNAL OF CLINICAL MEDICINE, INC.
1232-36 CENTRAL AVENUE
WILMETTE, ILLINOIS

CONTENTS

JUNE, 1950 — VOL. 57, NO. 6

Editorials

Original Articles

Problems in Practice

Thumbnail Therapeutics

(Continued on next page)

CLINICAL MEDICINE

JUNE, 1950

Volume 57, Number 6

CLINICAL MEDICINE published By the American Journal of Clinical Medicine, Inc.

Address manuscripts to:
The American Journal
of Clinical Medicine
Business Office:
1232-56 Central Avenue
Wilmette, Illinois

ORIGINAL ARTICLES, NOTES, AND REPORTS:

Are solicited for publication with the understanding that they are contributed exclusively to this journal.

Material submitted may be forwarded to a Staff Consultant for discussion and if approved will be published as soon as space, timeliness, and appearance of previously accepted articles permit.

Manuscripts should be clearly typewritten, double spaced, with ample margins. Legends for illustrations, and bibliographic references should be at the end of the manuscript.

Illustrations drawn by our staff artist and engravings from photographs or sketches submitted, will be provided by the journal to the extent of moderate cost; selections to be made by the editor.

Reprints will be furnished according to the schedule of prices which will accompany the galley proofs submitted to the author. Reprint orders, payable in advance, should accompany the returned galley proofs. The printer will hold type for one month following original publications.

This journal is not responsible for opinions or statements expressed by authors in communications or papers which have been published.

ADDRESS CHANGES:

Notify us promptly of any change of address, mentioning both old and new addresses. We cannot hold ourselves responsible for change of address unless we are notified as above. Complaints more than three months old cannot be honored.

RENEWALS:

Expired subscriptions must be expressly renewed within six months. Renewal notices will be sent by mail. Kindly always renew promptly.

$5.00 A YEAR — 50c A COPY

CONTENTS

(Continued)

COMING ARTICLES

Fractures in Infants and Children
The "Acute Abdomen" (Cont.)
Aureomycin in Acute Brucellosis
Diagnostic Error: Osteoclastoma
The Awareness of Responsibility

Entered as Second Class Matter August 1, 1942, at the Post Office at Wilmette, Illinois, under Act of March 3, 1879.

Editorials

The Physician Who Has No Time

One of the sorriest sights today is the physician who has no time; no time to enjoy himself, his family, his profession, his life.

It is so easy to get into the rush to heaven that one may rush by happiness and even health itself, before one realizes that it is too late.

The time to play with children is when they are small and now. The time to enjoy your wife and your home is now. The time to enjoy your practice is now.

The reason you don't enjoy these is that you "don't have the time." Part of this feeling of pressure is of course real. It stems from the fact that you have office hours, must be at the hospital, must make house calls and so on. How can part of this rush be avoided? In the first place, make your office hours short enough so that patients will have the pressure on them to report early instead of dropping in at all sorts of hours and making you wait for them.

In the second place, evening hours can be avoided under most conditions. If one night a week must be used, make it the night on which you do not especially want to be doing anything else.

You will not find that you are losing patients by cutting down office hours. On the contrary, you will gain them, because patients know that you will be there, and they will be perfectly willing to come and wait awhile to see you. When your hours are spread over a good part of the day and evening, they know that you must be gone at times and thus will not be available, even though they are your regular hours.

Learn to work with other physicians better so that they will be glad to take your turn when you want to go on a picnic with your family, or take the wife to the theatre, children to the zoo or circus, and so on.

During, and following, the war, many physicians have found that the other fellow isn't so bad after all, and that, although he will never do exactly as you would do under every possible circumstance, he can carry on as an emergency status, while you are relaxing; because you are willing to pinch-hit for him, the benefit works both ways.

It doesn't pay to be the youngest man with coronary thrombosis in the cemetery. (All the above leisurely remarks were dictated by the Editor while he was lounging in bed with such a high fever that he could do nothing else. It is very easy to be philosophical and be unwilling to push oneself when a fever of 104 deg. is keeping a hot hand on your forehead. The remarks are still true, however.)

True Malpractice Insurance

In many communities, doctors and insurance companies are in virtual collusion to prevent patients from recovering reasonable damage resulting from actual malpractice.

This is contrary to the public's interest, the interest of the patient, and to the long range interest of medicine.

The Alameda County Medical Association malpractice insurance never defends any case where there is a reasonable malpractice claim against the doctor. After investigation of the claim, and factual malpractice has occurred, the damages are estimated and the patient is offered a reasonable settlement. Where a reasonable amount cannot be agreed upon, it is the rule that the case should go to court with an open admission of responsibility, leaving only the amount of the damages to be determined by the court.

In cases where the committee determines that the physician is guilty of no act of malpractice, all offers of settlement are refused and the case is vigorously defended, even when it might be settled for far less than the cost of defense.

The physicians now feel that their malpractice insurance protects their patients as well as themselves.—The *Alameda County Medical Association Bulletin* August, 1949.

This is a welcome contrast to the usual malpractice in which the patient is denied any hope of recourse, regardless of how honest his claims or how unethical the physician may have been. (Ed.)

When To Suspect a Neurosis

Louis G. Moench, M.D., Salt Lake Clinic, Salt Lake City, Utah suggests the symptoms which lead to a suspicion, not a diagnosis, of neurosis:

1. Excessive or unusual fears or worries (such as fear of being alone).
2. Indecision, confusion, inability to make up one's mind.
3. Inability to find happiness in ordinary living.
4. Poor work or school record, or repeated change of jobs or residence.
5. Poor marital history: infidelity, divorce, incompatability.
6. Excessive shyness, sensitivity, or rage.
7. Alcoholism (excessive) or excessive smoking, or the use of sleeping pills.
8. Sexual concern: frigidity, impotence, ejac. praecox., satyriasis, etc.
9. Repetition of the same disturbing actions or thoughts.
10. Depression or discouragement at ordinary life events.
11. Excessive enthusiasm or other emotional response at ordinary life events.
12. Nervousness, dizziness, trembling, sweating of hands or feet.
13. Life-long history of headaches or fainting.
14. Long medical history, many doctors, rare diseases, unusual response to drugs or other treatments, and "almost died several times."
15. Repeated surgical operations, especially elective.
16. Repeated accidents.
17. Difficulty getting breath, lump in throat, or sighing respirations.
18. Pains in and around the heart, rapid heart, or skipping heart, esp. at rest.
19. Weakness, fatigue, tiredness after a night's sleep. Insomnia.
20. Tics, asthma, ulcers, dermatitis of the eczema-hives groups.
21. Pains and aches all over body: especially in eyes, back, head, pelvis.
22. Poor or excessive appetite. Marked obesity or thinness.
23. Constipation, diarrhea, stomach trouble, indigestion, gas, belching.
24. Multiplicity of symptoms and complaints.

Looking Frankly at Ourselves

Physicians rarely look at themselves either singularly or as a group. They are so conscious of the adulation of their patients, or the prestige of their profession that they tend to think that they can do no wrong. This is especially noted in their reaction to any criticism, whether justified or not.

Quite often criticism is dismissed by stating that the critic is not a member of the medical profession and thus knows nothing of the problems or opportunities in the medical field.

There are physicians who have a chance to view both the inside and outside aspects of medical practice. Such physicians are connected with both the public and the profession. Their viewpoints deserve recognition. Edward L. Turner, M. D., Dean of the School of Medicine, University of Washington, Seattle, Washington, has many interesting statements as he looks at medicine from the school approach.

Talking before the Illinois State Medical Society, he said "For too long, we have gone blithely on our way, endeavoring to be physicians, doing our work well and conscientiously, but almost oblivious to the current of political and economic struggle between the two great ideologies, the free enterprise of capitalism and the planned economy of stateism, that has been going on around us. Instead of carefully analyzing the situation and endeavoring to meet it with the intelligent, foresighted plans there has been a tendency to assume the attitude that 'what has been medicine's part of the picture must not be changed.' "

He comments that premedical work does not emphasize any of the social sciences but only science, science, and more science.

Of interest to our readers might be his statement that "general practice in itself should be a specialty. In my opinion, the great emphasis in preparation should be on diagnosis with the largest share of the resident's time allocated to medical diagnosis and rational therapy. The residency should also include sound training in *pediatrics, normal obstetrics and certain emergency surgical procedures.*"

He feels that medical diagnosis and correct treatment should receive the greatest amount of the resident's time and that such a residency should have a duration of two years.

At a recent meeting in Iowa City, your Editor was one of the delegates from the American Academy of General Practice to the faculty of the medical school at the University of Iowa. A residency in general practice will be established at Iowa City, beginning July 1st. These residencies will last for 2 years and will give the prospective general practitioner valuable, practical experience in the very problems that he will encounter when he leaves the hospital. The faculty was very agreeable to suggestions made by practicing general practitioners. They were not too well aware of the extent of procedures carried out by general practitioners in a preeminately rural state.

Turner points his finger at medical ethics and rightly says "the medical profession is made up of human beings with the same frailties and weaknesses as well as the strength inherent in all other human groups. Our ethical codes do make it mandatory to be the right kind of professional individuals. The public at least seems to feel that there needs to be some house-cleaning in our profession and that we as a group should not allow some of our colleagues to

carry on activities that discredit physicians. We are inclined to wait for the law to catch up with the known irregulars and borderline practitioners rather than see that they are hailed before the law by their professional brethren as undesirable physicians and citizens. Protection of such individuals is misguided ethics."

He feels that those physicians who filled out an assembly line technic during the heavy war load tend to still carry out such a technic, either for financial income or because their heavy overhead does not permit them to slow down and actually study the patient.

The speaker called attention to the person who is so aloof towards politics and civil service that he creates an impression of supercilious superiority that is simply maddening to the public. Such physicians feel that they can do no wrong and that their pronouncements on all topics must be accepted as complete and correct. They refuse to serve on committees that are for the public's good, or, if they do, do so in a careless and highhanded manner. All this is bad publicity for the medical profession.

Every physician should realize that as far as the public is concerned he is a leader in the medical profession. His actions and his words will help or hurt all other physicians.

The physician who is a good public relations agent goes about his tasks quietly and effectively . . . and, without "putting on the dog." The biggest and most expensive car in town, sometimes does not help in public relations. Dr. Turner states that "public relations consist of doing and not in talking."

In regard to the touchy matter of home calls, Turner calls attention to the fact the trend towards specialization has been associated with an ever increasing tendency to restrict practices to office hours and to avoid home calls. True enough, the average home call should be the province of the general practitioner. He points out also that calls have been refused that should have been made, or where help should have been obtained elsewhere for the patient.

If the physician can be of no avail in the home, he should make sure that some physician who is qualified does make the call, or if no one can be obtained, he should go himself if to do nothing more than render first-aid.

We all live in glass houses but we should all get in and help the patient toward the best possible service.

—R.L.G

Postgraduate Study in Your Office

The payoff is the patient. You may read articles, visit medical meetings attend postgraduate courses, but unless the patient receives improved care, your time and effort has been wasted.

The payoff is the patient. The first problem is to make an accurate diagnosis. The first study, therefore, is the patient. He is not neatly labeled "cardiac disease," "gall bladder disease" or "psychoneurosis," indeed, he may have symptoms or signs of all three.

How can you learn to improve your batting average?

1. Let your patients teach you, follow up your diagnoses and those of specialists. Time is the best diagnostician of all.

2. Attend clinicopathologic conferences: The pathologist is a good diagnostician.

Pediatric Surgery*

The Child As a Surgical Problem

by R. L. GORRELL, M.D., *Clarion, Iowa*

In the infant, the usual problem is one of:

Obstruction or inflammation

Not a good risk after 48 hours;

Use plasma or hypodermoclysis, *not* blood, as Hb often 115%. Give no blood unless indicated, check hemoglobin. Hb 60% or less definitely indicates blood. Prevent shock with plasma 10 to 15 cc. per lb.

Vomiting in infants: Not bile stained-obstruction above ampulla. Bile stained—below ampulla Vater

Surgical condition present? Infants-vomit. Children—have pain.

Flat abdominal x-ray: Study gas pattern of stomach duodenum, as for atresia, small intestine. Never give oral barium, especially if atresia or obstruction (barium pneumonitis from aspirating vomited barium); use lipiodol, if necessary.

New born should show gas along entire GI tract to anus. If not all visualized, small intestine obstruction (colon not gas containing).

Premature: Normal time for gas pattern not known; wrong diagnoses by radiologist has caused operation for obstruction not present.

Take flat x-ray on all surgical problems, but use clinical judgment; listen carefully to mother's history, frequently she will make the diagnosis if you take time. Don't depend upon lab. or x-ray to make diagnosis. Do careful physical exam. sit by bedside.

Get ready for surgery with fluids; watch especially for subnormal temperature, and warm baby. Watch operating room temperature, so baby doesn't get chilled; speed not hurry; very exact hemostasis; do only the one surgical task and get out. Leaving operating room, give plasma for shock or shock-like pitcuture.

Anesthesia is vital; don't fight the bowel; cyclopropane plus a little curare often relaxes well.

Diagnosis

Child's surgical condition: Take time to establish diagnosis.

Pain: Before or after feeding—defecation—urination.

A child's complaint of pain means definite disease, e.g. pyelitis. When a baby cries and is not hungry, pain may be cause. The mother can usually differentiate from ordinary colic.

Infant's position: What position does the baby assume? Knee-chest, colic indicate an intussusception, in babies 4 to 12 months. The pain may be mild.

Rule out the condition the mother fears. She often has an insight into the baby's condition.

Circumoral pallor plus an anxious look plus moderate pain often indicate appendicitis. The infant looks apprehensive.

Don't hurry to examine the abdomen, or voluntary rigidity will detract from the palpation.

Don't ask leading questions, if the child is older than 10 or 12.

Appendicitis pain is often mild to moderate, rarely severe. It is rare in first 2 years of life, especially in the first, but common from 4 to 12 years. It is usually overdiagnosed in the first year of life. Usually in the first 2 years, the diagnosis is not clearly made until it has ruptured. Examine the infant again in 3 hours and again in 6 hours; if the process continues, operate at once.

Remember intussusception, volvulus.

Doctors don't have enough horse sense!

Intussusception: Pains may resemble those of "labor" pains, or pains may be mild. Pains may resemble other intestinal obstruction. All children re-

*(Notes by R. L. Gorrell, M.D. taken at a postgraduate course in pediatric and traumatic surgery given by The Center for Continuation Study, University of Minnesota Medical School, Minneapolis.)

fer pain to the umbilious, regardless of cause, if it is in the abdomen.

Mesenteric Lymphadenitis: Differential diagnosis is impossible from acute appendicitis. Lymphadenitis doesn't recur after appendectomy.

McBurney incision: Only good for removing a normal apex. The apex is often high in children, as the colon hasn't descended. Use a right rectus muscle splitting incision.

Plasma: Use fresh plasma instead of pooled, so no danger of infections hepatitis. If low Hb and red cell count, give whole blood. Use 3 or 4 hours postop. If shocklike picture develops; plasma just as effective as blood in infants for shock, unless anemia is present.

Appendicitis vs. enteritis: A tremendously important differential diagnosis because enteritis is so common.

Which came first, diarrhea or pain:

1. If diarrhea first, enteritis is prob. diagnosis.
2. If pain first, then diarrhea, may be a very acute appendicitis plus peritonitis.
3. If typical enteritis with diarrhea, then pain after several days and point tenderness—appendicitis.

Atropine should be avoided entirely in children; possible cause of death "ether convulsion."

Inguinal Hernia in Children.

If the parent establishes a story typical of inguinal hernia, the physician must rule it out, even if no hernia can be seen or felt at the time.

The finger may be placed over the internal ring (which in infants is almost directly behind the anterior or external ring, as the canal is almost straight), and rotate. After some practice, the sac can be felt, which feels like a moist empty finger cot, in contrast to the other side.

Look for the impulse. Have the nurse or mother use a tongue blade in the infant's throat, to make it strain and force a hernia down, which might not be visible otherwise.

Differential diagnosis: 1. Enlarged inguinal nodes are tender, (hernia is not tender unless incarcerated), often multiple, a source of infection can often be found. You "cannot get above a hernial sac," an enlarged node in the inguinal canal, hydrocele or spermatocele can be gotten above.

2. Complete hydrocele, which is open throughout, with fluid running back in when patient lying down, is usually associated with hernia. At surgery, the differential diagnosis is made.

3. Undescended testes—small, soft in infants; usually a hernia is associated with undescended testes in infants.

Reduction of hernia: Don't attempt more than twice, or may damage bowel. Trusses usually of little avail, but may cure a small percentage of patients.

Anesthesia for herniotomy: Use little ether as it is irritating. Pentothal plus curare is very effective.

Technic: Use sharp dissection rather than gauze covered finger which tends to bruise tissues and rubs away blood supply. Be careful not to injure blood supply while dissecting around cord structures. Leave cord posterior so testes can be kept in *bottom* of scrotum (this is also true of undescended testes).

Avoid injury to testes with subsequent atrophy following post-operative swelling. "Be careful of cord structures.

Intraperitoneal approach in infants: To avoid injury to cord, make a transverse incision 1 inch above internal ring, cut rectus fascia transversely, rectus lengthwise and peritoneum vertically. Incise ring of hernia (neck); ligate sac and leave in place. Close peritoneum. No testicular swelling follows this surgical procedure.

Complications — hernia: Strangulation has a high mortality rate. Use external approach. Be sure bowl is viable. Prevent strangulation by operating on all hernias as soon as possible. Surgery at any age indicated, especially after age 6 months.

Paint incision with plastic solution which dries and prevents urine and feces from contaminating it for several days (vinyllite resin—like collodion).

Swollen testicle may be treated by incision to prevent later atrophy (as is done in mumps).

Anesthesia in Children

As in adults, the respiratry—circulatory—nervous functions must be preserved and electroylte balance maintained.

Premedication: ¾ to 1 hour prior

Morphine is taken well, more reliably than in adults and larger dose according to size; (all sedation based on basal metabolic rate) (all anesthesia based on basal metabolic rate) 6 months to 1 year give 1/40 to 1/60 gr. depending upon size and vigor and anemia; May give as little dose as 1/140 gr.

Belladoenna group: cause disturbed reactions; dose is uncertain; stimulate basal metabolism

Reactions: Flush, oral pallor—Hot skin—Fever and convulsions—hyperpyrexia—Tachycardia

Don't operate if fever 100 to 105° wait until reactions pass or operate upon another day

Be sure that full effect has occurred before beginning anesthesia or tachycardia will be confusion; if flush is present, full effect has occurred.

May use scopolamine instead of atropine. Additional atropine intravenously for bradycardia or arrythmnia during operation, especially during chest operation.

Barbiturates depress respiration: Possibly ½ gr. Nembutal may be given rectally if nervous or Pentothal rectally ½ cc. of 2½ percent solution per pound of babies weight. Relation begins in 10 minutes.

Inhalation anesthesia: The dead space is greater in children; air is unchanged; no increase oxygen or decrease carbon dioxide in dead air space.

Gauze masks: If dry and no anesthetic, 16 percent oxygen is present; if ether added, 12 percent oxygen is present. *Small masks should be used,* so dead space is small and most of exhaled vapor is pushed out. Towels over mask decrease exchange of gases, decrease oxygen, increase carbon dioxide and acidosis. Keep mask loosely on face.

Anesthetic convulsions in children: More tendency if fever or toxemia and if oxygen decreased and carbondioxide increased.

Machines: Can use adult inhalation machines; better results than with drop ether. An intratracheal tube is not damaging to trachea; if used with oxygen bag compression, dead space is eliminated.

Induction: Use vinethene (avoids chloroform dangers) it is safe as it evaporates fast, is out of circulation fast; must gradually add ether to mask as divinyl ether (vinethene) evaporates so fast and has such a transient action.

Cycloppropane is excellent; quick induction, non-irritating; rarely cause cardiac standstill (vagal reflex) as stimulate aparasympathetic.

Tonsil anesthesia: Machine ether or cycloppropane. *Drop ether* is most dangerous, causes an increased mortality; it is hard to maintain an open airway and good respiratory exchange. *Respiration may stop without notice* if tongue is depressed; death follows if lack of oxygen occurs plus complete respiratory obstruction for a few breaths. Don't get so deep anesthesia that the patient hasn't strength enough to gasp.

All tonsillectomies at University of Minnesota must have intra-tracheal tubes, small, non-irritating; use English wax plus rubber Magill tubes; graduated sizes very pliable (from Ohio Chemical Company) English plastic tubes, Portex Sold by Hawks

Hypnotics: Avertin or Pentothal are hypnotics, not anesthetics, as they don't stop reflexes or different impulses. Good to put to sleep not for anesthesia. They must be supplemented as dose cannot be gauged accurately enough. Dose of Avertin is 100 mg. per kg. body weight in child.

Pentothal plus curare avoids laryngospasm in infants. Pentothal alone doesn't top reflexes; curare keeps quiet. Allow the patients to move a little; keep anesthesia light. 100 mg. pentothal plus 3 mg. of d-turbocurare in 5 cc. syringe with fine graduations, so very small dose can be measured, as ¼cc. Remember it is easier to inject in vein when patient asleep. May be put asleep with nitrous oxide, then pentothal-curare given, as for tonsillectomy.

Any anesthetic that adults can take safely, children can also. Spinal anesthesia may be used, as 4 mg. Pontocaine in 5 year old child. Positioning very important in children as relatively short distance to move anesthetic solution in spinal canal.

Acute Abdomen Round Table

Pediatrician: Differentiating upper respiratory infections from acute abdomen.

Respiratory infections and appendicitis may coexist; or respiratory infections may cause appenticitis.

Respiratory infections in children are caused by a virus in 90% of cases; so no need for antibiotics in most cases.

Upper respiratory infections: *Coryza* 1 or 2 days incubation. *Sore throat* 5 days incubation. Both are immunologically distinct, both may go on to pneumonia. Measles may progress to pneumonia.

Exudative tonsillitis: May be non-bacterial even though follicular or may be complicated by Beta-hemolytic streptococci in ¼ cases (if all cases are cultured, ½ will develop B-hemolytic streptococci but only ¼ are pathogenic).

Exudative tonsillitis is a common cause of abdominal pain in children;. frequently causes repeated vomiting, high fever and a normal leukocyte count.

This is one of the commonest diseases found in house calls on children and infants.

Measles: Rubeola or "regular" measles, a respiratory disease with leukocytosis, cough, Kopliks spot. Rubella is not a respiratory disease.

Influenza is caused by virus A or B, a respiratory virus. It should be diagnosed only when an epidemic is on. It does not cause abdominal pain or diarrhea (there is no "intestinal flu"). It is immunologically distinct. Patient is toxic, fever 103° F., lassitude, white blood count 9,000 in acute cases (measles has a leukopenia as does typhoid)

Undifferentiated respiratory infections: Are common now, as contrasted to former incidence of lobar pneumonia.

Pneumonia: Vomiting may be cardinal symptom (appendicitis may coexist). Today a typical pneumonia covers 90 percent.

Pyuria (acute pyelitis) especially in girls must be ruled out.

Primary peritonitis especially found in girls; higher fever and white count (1 also true in pneumonia); treatment causes dramatic response.

Acute appendicitis causes little fever (up to 101° F.) unless ruptured moderate leukocytosis unless ruptured. Aureomycin may be of good leukocytosis value in appendicaeal peritonitis.

Once an attack of appendicitis has occurred, surgery is always indicated. If appendix has once perforated, there is a very high incidence of recurrences; ⅓ will have appendicitis within 3 months and 1/6 will reperforate.

Pinworms: are found in 40 percent of northern children, almost 100 per cent of southern children, according to some observers. They can cause pain, rarely can cause obstruction if they collect in balls. Rarely, pinworms can cause appendicitis.

It is a self-eliminating disease, if every member of the family is treated, all members wash their hands before eating to prevent reinfection, and 3 courses of gential violet is given.

Surgery

For purposes of comparison, experimental appendicitis was produced in animals and in human beings undergoing colon resections, by ligating the base of the appendix.
Fever, Pain, Leukocytosis followed ligation appendix base

Fluid is secreted by appendix until pressure forces it into cecum, in normal circumstances. Obstruction to the lumen of the appendix is the chief cause of appendicitis. The normal appendix resists pressure, possibly due to muscle tone. This resistance to pressure indicates that the appendix resists more pressure than your auto tire.

83 percent of patients with gangrenous appendicitis has a previous history of attacks; 17 percent showed fib-

rosis, indicating that previous appendicitis had occurred. Previous appendicitis may have been asymptomatic (silent).

Leukocytosis and fever are late symptoms; such serious situations as gangrene and perforation may have occurred before leukocytosis and fever have occurred. Pain is due to tension in the appendix. Local tenderness is usually the first sign.

In a large series of patients who had received typhoid immuniations, there was 6 times as many cases of acute appendicitis in the following 3 weeks.

Wyatt: In a ruptured appendix with mass formation, antibiotic treatment and rest may be carried out and often the mass will absorb in 1 week; operation can be carried out in 3 weeks. Wangensteen (gastrointestinal suction) suction need be carried out only if pain and vomiting persist without its use.

The "Crippled" Appendix

The pediatricians do not recognize the crippled appendix. Surgeons feel that after appendicitis has occurred, the appendix never returns to normal and much improvement occurs after its removal. The crippled appendix can be detected only by the history, but 50 percent of such patients have had suppurative appendicitis. This is proven by the fact that almost 50 percent of appendixes removed routinely during gynecologic operations are found to contain pus or other evidences of acute appendicitis. Many asymptomatic patients have appendicitis. There is no safe period to wait after the diagnosis of acute appendicitis has been made; the appendix may rupture at any time. The patient is never safe after an attack of appendicitis, as it may recur after months or years of apparent health.

Pathologically, the appendix removed 6 to 12 weeks after it has perforated, will be called "inactive appendix" or no acute inflammation. (Dennis) Old Luekocytes are eliminated through the gastrointestinal tract, so some leukocytes in the appendiceallumen is a normal finding; if increased, the diagnosis is made of "catarrhal appendicitis."

Pain that moves about the abdomen is usually not due to acute appendicitis. If true appendicitis is present, remove the appendix despite the presence of almost any other disease.

In children, the presence of anorexia and vomiting may be important. If a child suspected of acute appendicitis eats a meal, enjoys it and does not vomit, operation should be deferred and further study made.

Occasionally acute appendicitis causes intestinal obstruction; remove appendix if obstruction not relieved in 6 hours.

If appendectomy cannot be carried out in acute appendicitis (as on ship) may relieve with huge doses of antibiotics.

Differential diagnosis appendicitis: Acute pancreatitis very rare in children. *Rheumatic fever:* Ask about severe nose bleeds in preceding weeks, wait for sedimentation rate which is usually elevated in rheumatic fever; examine appendix pathologically, Aschoof bodies may be found in it. If the abdomen is opened and free clody fluid found which is negative on culture, the diagnosis of virus peritonitis may be considered.

Intussusception: Common but often overlooker and called colic," as it reduces spontaneously; occurs younger than 2 years; usually in robust, apparently healthy infants.

Sudden onset of abdominal pain, which lasts for 30 to 90 seconds, then recurs every 4 to 10 minutes, followed by vomiting, loose bowel movement containing mucus and blood. The patient assumes the knee chest position or on all fours.

After a few hours the symptoms decrease, even if the intussusception is not reduced; both mother and physician have a false sense of security for 1 or 2 days, then symptoms of obstruction, leukocytosis and fever occur, due to strangulating intestinal obstruction.

Take the history first, then examine the youngster. Have nurse or mother hold the infant up with a hand in each axilla; palpate the abdomen with one hand against the finger in the rectum and feel for the mass of intussusception.

Parenteral *Vitamin E* Therapy

Experimental Results in Basal Cell and Squamous Cell Carcinomas and Varicose Ulcers

by MARCUS T. BLOCK, M.D., *Newark, New Jersey.*

In 1948 Burgess and Pritchard[1] reported on the use of Vitamin E* administered in comparatively large doses for non-ulcerative granulomatous lesions, collageria and venous stasis with ulceration of the legs[2].

Burgess has reported good results with mixed tocopherols in the treatment of diseases in which there was collagenous degeneration including one patient with a chronic granulomatous ulceration of long standing which was diagnosed histologically as necrobiosis lipoidica diabeticorum. The patient was given 750 mg. of mixed tocopherols intramuscularly over a 10 day period. Favorable response was evident within a week, but oral tocopherol therapy was continued for four months. Because of their excellent results it was thought that vitamin E might be tried experimentally in the therapy of other skin and subcutaneous ulcerative lesions as well as in ulcerative carcinoma of the skin and leukoplakia.

Twenty-eight patients were given aqueous vitamin E parenterally in 75 milligram quantities following the schedule described below. The patients selected for treatment had received other forms of therapy including X-ray, ascorbic acid, penicillin, bacitracin and chlorophyll. These other forms of therapy had failed to bring about healing of the lesions.

The patients ranged in age from 30 to 70 years. The conditions treated are shown in Table 1.

*The vitamin E employed was Hydrotocopherol supplied by Farnsworth Laboratories Inc., Chicago, Illinois.

Of the patients with basal cell carcinoma, all but two were treated by this method after X-ray therapy with curetage, following the method of MacKee and Cipollaro, failed to produce healing. The diagnosis of basal cell carcinoma was confirmed by biopsy in all cases. When no response to roentgen therapy occurred, treatment with vitamin E was instituted.

The treatment schedule followed was 75 mg. daily for from 3 days to one week, then 2 injections were given weekly until 25 injections had been administered.

Results in Dermal-Carcinoma

Excellent results were obtained in practically all cases. Ulceration healed within 5 days to one week with disappearance of redness and scaling. In patients in whom no roentgen therapy was employed (1 treated with carbon dioxide snow and the other by cautery) the lesions recurred after about 6 months. Five daily injections of vitamin E in 75 mg. dosage produced completely healed areas.

Case Reports

Mrs. McW., aged 50 had a carcinoma of the pelvis, later determined to be a squamous cell epithelioma. She had a pan-hysterectomy and 3 months later there was recurrence of the nodules in the vagina. Six injections of vitamin E administered twice weekly brought about complete involution of the lesions.

Mrs. D., aged 48, when first seen had roentgen ulcerations following intensive X-ray therapy for a basal cell carcinoma located anterior to the right ear.

Six injections of vitamin E given daily brought about complete healing with heavy cicatrix formation.

Mrs. B., aged 50, had a pseudocystic basal cell carcinoma involving the skin near the inner canthus of the eye. This patient had not been treated in any way when first seen. She was given 8 daily injections of 75 mg. of vitamin E. Almost complete involution had occurred within 5 days and there has been no evidence of recurrence.

In the 13 patients with varicose ulcer and varicose eczema complete healing was produced by vitamin E therapy. The longest period required was 20 days, the shortest 3 days. Local therapy with a zinc paste was also employed and infection was first controlled with penicillin and wet dressings.

The 2 patients with leukoplakia were given 6 injections at weekly intervals which produced clearing of all ulcerating lesions. Most of the leukoplakia disappeared.

In the 1 patient with subacute lupus erythematosis, the lesions rapidly became intensified after the injections of vitamin E. However, involution followed the discontinuance of the vitamin E therapy and the administration of penicillin.

On a second case with chronic discoid lupus erythematosis, the lesions disappeared with 5 daily injections.

Excellent results were obtained in a patient with diabetic ulcer resistant to other forms of treatment. The lesion had been present for 5 months. It cleared up rapidly after the administration of only 3 injections of 75 mg. of vitamin E.

Conclusions

In a series of cases reported, vitamin E parenterally in large doses evidently produced sufficient collagenous regeneration to check the growth of abnormal cells. Whether or not such therapy produces a complete cure cannot be stated at present. The benefits obtained, however, would appear to make this form of treatment well worth trying in conditions in which there is a state of collagenous degeneration.

Reference

1. Archives of Dermatology and Syphilology, April 1948.
2. Lancet 1948, Canadian Medical Journal, September, 1948.

The culture of the mind must be subservient to the culture of the heart.—GANDHI

The Physician's Office a Diagnostic Center

If the aid of competent specialists can be obtained, the general practitioner can make his office a diagnostic center. The cardiologist examines and interprets the electrocardiograms and chest films, the pathologist interprets routine smears from the cervix as to the presence of early malignancy (he may also look for cancer cells in sputum, urine, puncture fluids and biopsy) and examines abnormal blood smears. The roentgenologist examines all films, except those of very obvious conditions such as fractures.

Routine skin tests for tuberculosis on all patients reveal an occasional case of tuberculosis.

Routine physical examinations disclose many abnormalities that may lead to cancer, i. e. erosions and infections of the cervix, various tumors of the breast, lesions in the mouth and so on. Routine ophthalmoscopy will disclose arteriosclerosis and suggest investigation of vital organs that may be involved.—

—R.L.G.

The "Acute Abdomen"
PERITONITIS

(Joseph Levitin of San Francisco summarized the value of a simple abdominal x-ray or "flat film" for the recognition of acute abdominal lesions in a *Clinical Medicine* article. Because of lack of space, his case reports, with roentgenograms, must be published serially.—Ed.)

Case Number 4

A male, aged 44 years, had a sudden onset of pain in the epigastrium with nausea and vomiting. Pain later settled in the right lower quadrant. After about 12 hours the pain decreased but some nausea still present. The following day the patient started to become distended and experienced some nausea and vomiting. Examination on the third day showed a toxic patient with distended abdomen. No localized tenderness was present. White count was 15,000, 90 per cent polymorphonuclear cells. Film of the abdomen showed distended loops of small bowel, some gas in the colon and some gas in the stomach. Lateral decubitus view showed distended loops of small bowel containing fluid, which were fixed in position. The loops tended to be shallow and were scattered over the abdomen. Diagnosis; peritonitis. At operation a ruptured appendix and peritonitis were found.

PROBLEMS IN PRACTICE

(CONSULTATION SERVICE)

Prevention of Malpractice Suits

Prevention is the best defense against malpractice. The following briefly outlined measures have been found to be effective and have been recommended, in whole or in part, by all who have given consideration to the problem of malpractice:

1. The physician should care for every patient with scrupulous attention to the requirements of good medical practice.

2. The physician must know his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. "Ideal" medical records should be kept in every case: records that would be presentable when offered in court; records that clearly show what was done and when it was done; records that indicate that nothing was neglected and that the care given fully met the standard demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the record should show it; a good method is to file a carbon copy of the letter which advises the patient against the unwise course.

5. The physician should be careful to avoid making any statement which constitutes or which might be construed as an admission of fault on his part. Such an admission, which is usable against the physician, might be made to a third party as well as to the patient an any time before the trial. Such an admission may be made by an agent or employee of the physician during the course and within the scope of the employment. It is important to instruct employees to make no statements.

6. The physician should exercise tact as well as professional ability in handling his patients. A proper professional manner and a sound attitude should be maintained at all times, both toward the patient and toward the patient's family. The attentive physician may early sense some unsatisfactory and disturbing undercurrent, which may be prevented by the institution of protective measures, from developing into something much more unpleasant. Thus, if the patient is not doing well, consultation may be suggested; if the patient is dissatisfied or complaining, or if the family's attitude indicates dissatisfaction, consultation should be demanded. The use of a consultant affords, in any case, great protection against a malpractice claim.

7. The physician should refrain from over-optimistic prognoses and should avoid promising too much to the patient.

8. The physician should advise his patients of any intended absence from practice and should recommend, or make available, a qualified substitute.

9. The physician should unfailingly se-

cure written consent for operation and for autopsy.

10. There should be careful supervision of assistants and employees and great care in the delegation of duties to them.

11. The physician should have some knowledge of the Statute of Limitations and of its significance.

12. In his selection of patients the physician should limit himself to such fields as are well within his qualifications. He should keep abreast of progress in the medical profession.

13. The physician should keep inviolate all confidential communications.

14. He should frequently check the condition of his equipment and make use of every available safety installation.

15. In the treatment of the patient the physician must not experiment.

16. The physician must be careful to render sufficient care to his patient in general instructions, frequency of visits, clinical and roentgen ray laboratory investigations and the like. Moreover, every precaution should be instituted for the protection of those caring for the patient and of all other contacts.

17. The patient must not be abandoned. The physician-patient relation can be terminated without liability only in certain ways and under certain conditions.

18. The physician should never reveal that he carries professional liability insurance. He should never write a letter or make any statement with reference to a malpractice claim, except on the recommendation of his legal adviser. Immediately on being advised of even the possibility of suit he should consult with his attorney.

19. The physician should arrive at an understanding in the matter of fees. Misunderstanding in this matter, particularly when the question of excessive fees arises, contributes an avoidable element of risk.

20. The physician should secure legal advice if he is called to attend a coroner's inquest as a witness in a case in which he has been in professional attendance.

21. The physician should realize that because of the possibility of error in transmission, it is dangerous to telephone a prescription.

22. The physician should realize that it is hazardous to sterilize any patient except when a medical indication exists.

23. Except in actual emergency, no female patient should be examined unless a third person is present. There is no more serious or destructive charge in the "malpractice book" than that of undue familiarity; and the only way to avoid claims of this sort seems to be to have some one else present during all examinations. — L. J. Regan, M.D.—*J.A.M.A.*, Nov. 12, 1949

Overlooking the Very Early Patient With Psychosis

Question:

Now and then a patient appears whose complaints make no sense at all. How can I tell if a psychosis is just beginning to appear? M.D., Taos, New Mexico.

Answer:

L. G. Moench of the Salt Lake Clinic, Salt Lake City, Utah, has well written on clues to an early depression and to schizophrenia (split personality):

A. Certain depressive signs are easily seen:

1. A depressed, "sour-puss" demeanor. The patient may try to be pleasant and gay, only to burst into tears unexpectedly.

2. Restless agitation—wringing the hands or repeated stroking of the body or demanding that the accompanying relative "take me home."

3. An endless "organ recital" of complaints — especially those centering around the narcissistic areas, the head and the pelvis.

4. Blocking, reluctance to talk about or excessive emotional responses to thoughts of certain events—such as the

woman who, two years after the death of the husband, continues to talk of nothing else and cries whenever she talks of it.

5. Ideas of sin, of guilt, of punishment or of influence by supernatural evil personages. Often the patient in a depression searches his past life and tries to assign a causative role to any previous indiscretion or defection, real or fancied.

6. Somatic symptoms, often simulating carcinoma.

7. Reference to self destruction. The truly depressed person may be quite sincere and serious, and his warning may be an appeal for help.

B. Certain clues, although not diagnostic of schizophrenia, may serve to heighten our suspicion:

1. Inability to communicate—the feeling of talking at the patient, not to him.

2. A list of symptoms that fall through the grasp like water from a sieve, or a list of symptoms so bizarre that no one syndrome could explain all of them and no one organ could be capable of so much mischief.

3. Frequent failure of the patient to convey an adequate or entirely plausible reason for the visit. If pinned down by the detective where-do-you-hurt interrogation, he may dwell on some minor ache or pain as a face-saving device, or may actually invent a pain and then himself believe that it exists. Or he may be preoccupied with his own thoughts or sensory misinterpretations.

4. Suggestions of reference or influence—the patient is being forced against his will to do or think certain things. He may be suspicious, and concerned over dictaphones or harmful "rays" from an air-conditioning unit.

5. Behavior out of context of the situation—laughter while discussing the cause of the father's death, or tears while discussing dietary habits, or odd posturing, grimacing or repeated mannerisms.

6. Resistance—as one patient said to his mother, "You can make me go to the doctor, but I won't tell him anything." (He can't have any of my precious thoughts.)

7. Excessive concern over abstract problems, social, religious or philosophical issues, or exaggeration of self esteem.

8. Difficulties in emanciapation from a parent—a mother bringing in a son 24 years of age is a frequent clue.

The Lord may forgive us our sins, but the nervous system never does.—WILLIAM JAMES

Educating Your Allergic Patient

Now and again a book comes along that is a real help in explaining to a patient what the physician can and cannot do for him and how the patient can help himself, what the future may hold for him and something of the nature of his body and/or the abnormal condition that distresses him.

"Primer of Allergy"* is such a book. It explains that a patient may be perfectly diagnosed and treated with relief of allergic symptoms but that he may, at any time, become allergic to other things and have a recurrence of symptoms or new symptoms may appear. It explains that allergens are to be found in groups and that the patient may thus be cautious about any food or inhalant in the same group.

This small volume will save the physician's time and will make the allergic patient more tolerant of himself, his condition and his doctor.

* Vaughan, Warren and Black, J. Harvey: Primer of Allergy. C. V. Mosby Company. 1950. $3.50.

The Bleeding Diseases

Question:

How may one begin a differential diagnosis between the various conditions causing abnormal bleeding? I know that a hematologist may be required in the rare conditions.—M.D., Seattle, Wash.

Answer:

With the use of a few tests that can be performed by any general practitioner, one may *begin* the differential diagnosis of hemorrhagic diseases:
(By John A Kolmer, M.D. in "Clinical Diagnosis by Laboratory Examinations" Appleton-Century-Crofts, Inc.—$12.00)

Disease	Coagulation Time	Clot retraction Time	Bleeding Time	Capillary Fragility
Pernicious anemia	Normal	Poor	Prolonged	Variable
Aplastic anemia	Normal	Poor	Prolonged	Negative
Sickle cell anemia	Normal	Normal	Normal	Negative
Hypochromic microcytic anemia	Normal	Normal	Normal	Negative
Agranulocytosis	Normal	Normal	Normal	Variable
Infectious mononucleosis	Normal	Normal	Prolonged	Negative
Purpura hemorrhagica	Normal	Poor	Prolonged	Negative
Henoch's Schonleins purpura	Normal	Normal	Normal	Negative
Hemophilia	Prolonged	Normal once formed	Normal	Negative
Hemorrhagic disease newborn	Prolonged	Poor	Prolonged	Variable
Hereditary hemorrhagic telangiectasia	Normal	Normal	Normal	Negative
Acute leukemias	Normal	Poor	Prolonged	Negative
Chronic lymphatic leukemia	Normal	Normal	Prolonged	Negative
Hodgkin's disease, thrombocytopenia	Prolonged	Poor	Prolonged	Negative
Multiple myeloma	Prolonged	Poor	Prolonged	Positive

Thumbnail Therapeutics

Combined Antibiotic and Sulfonamide Therapy

Numerous infections, although caused by organisms which appear sensitive to a given antibacterial agent in vitro fail to respond to the same agent in actual infections. A combination of existing antiobiotics to form a more effective and synergistic method of treatment is often useful, e.g. penicillin is synergistic with streptomycin, aureomycin and sulfadia zine; streptomycin and sulfadiazine, sulfamerazine; and chloromycetin with sulfamerazine and sulfathiazole.—C. W. PRICE, M.D. (Food and Drug Administration, Federal Security Agency, Washington, D.C.) presented before the American Public Health Association.

Prevention of Gonorrhea with Oral Penicillin

The oral administration of a 250,000 unit penicillin tablet within 2 to 4 hours of exposure is often effective in preventing the development of gonorrhea.—H. EAGLE, M.D. in *Public Health Reports*, Oct. 20, 1948. (This sounds wrong not only from the moral but from the medical standpoint. It would seem to encourage or invite illicit intercourse and to promote the development of penicillin-resistant gonococci.—Ed.)

Chemical Burns of the Eye

Immediate washing out of an eye with water or isotonic sodium chloride solution is the only immediate, practical treatment for chemical burns of the eye. This may be followed by a local anesthetic, and penicillin ointment. Reference to an ophthalmologist may then be carried out.—W. MORTON GRANT, M.D. (Harvard University Medical School) 243 Charles Street, Boston, 14, Massachusetts in *J.A.M.A.*, Jan. 21, 1950.

Hormone Therapy for Advanced Breast Cancer

Testosterone (male sex hormone) may be administered for advanced breast cancer, regardless of the age of the patient, when metastatic lesions of the bones have appeared. 100 mg. of testosterone propionate is given parenterally 3 times weekly for 10 weeks, followed by an oral maintenance dose of metnhyl testosterone of 60 mg. daily for ten weeks. Pain decreases, sleep becomes natural, appetite improves and a general improvement is noted, in those patients who will respond. It has no effect on the primary malignant disease or soft tissue metastases.

Estrogen therapy is beneficial in hopelessly advanced soft tissue breast cancer lesions, often causing temporary regressions in the primary tumor, metastases, lymph nodes and lung lesions; pain may be relieved and a general improvement may occur. 10 to 15 mg. of oral estrogen (stilbestrol) is given daily. Estrogen therapy should never be given to any patient who is still menstruating or who has menstruated within 5 years. It accelerates the growth of carcinoma.—*N.Y.S.J.M.*

Treatment of Tinnitus (Buzzing in Ears)

Tinnitus may be treated with intravenous infusions of histamine phosphate, oral nicotinic acid and one of the bromides.—*Digest Ophthlalmol.*, Dec. 1948.—

Treatment of Acute Vertigo with Sympathetic Block

An acute attack of Meniere's disease may be treated by novocain injection of the stellate (cervical) ganglion on the same side.—E. R. G. PASSE, F.R.C.S. in *Brit. M. J.*

DIAGNOSTIC POINTERS

Small Heart Size

When a small heart is noted on examination, one should suspect Addison's disease (lessened function of the adrenal cortex). Hypotension is usually found. The electrocardiogram may show definite abnormality (inversion T_1 and CR_7). The chest x-ray will show a small heart that enlarges rapidly after therapy with salt and synthetic adrenal cortex. If the heart becomes too enlarged and hilar shadows appear, too much salt is being given; it must be stopped immediately. W. Evans, N.D. M.D. in *Proc. Royal Soc. Med.* Eng., May 1949. (Simmond's disease, or anterior pituitary deficiency may cause the same cardiac effects).

Cardiovascular Syphilis

Suspect cardiovascular disease when there is evidence of localized aortic bulging, altered aortic second sound, aortic systolic murmur in persons under 40 years without hypertension, precordial pain, unexplained shortness of breath or nocturnal dyspnea, high pulse pressure and water-hammer (Corrigan) pulse. —Handbook for Physicians, Venereal Disease Education Institute, Raleigh, N.C.

Chronic Diarrhea

Chronic diarrhea is due to chronic idiopathic colitis, to no discoverable organic cause, following dysentery, carcinoma of rectum or colon and rarely to parasites, thyrotoxicosis, pancreatic disease, idiopathic steatorrhea and tuberculosis. Emotional tension was connected with three fourths of such cases, including those under "colitis." A. Abrahams, M.D. in *Proc. Royal Soc. Med. Eng.*, Apr. 1949. Idiopathic steatorrhea responds dramatically to injections of folic acid.—A. Morton Gill, M.D.

Diagnosis of Multiple Sclerosis

Intention tremor (patient tries to touch nose).

Nystagmus (mostly horizontal oscillations).

Scanning speech.

Urogenital disturbances (urinary, rectal incontinence, impotence).

Loss of

Abdominal upper / middle / lower

Reflexed (Babinski, clonus)

Sensory disturbances (loss vibratory or proprioceptive sense). Hans Reese, M.D. Univerity of Wiconsin Medical School, Madison, Wis.) in *Postgraduate Medicine*, Aug. 1949.

Mental Disturbance

Suspect neurosyphilis in every case of mental disturbance.—Diagnosis of Syphilis, Venereal Disease Education Institute, Raleigh, N.C.

The Patient Who Makes His Own Diagnosis

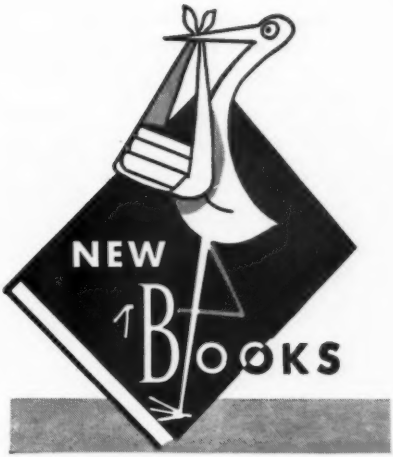
Patients who make their own diagnosis of neurosis or difficulties of emotional origin frequently have organic disease, and the reverse is much more frequent, that is patients who insist "something being found" usually do not have organic disease.—Weis and English "Psychosomatic Medicine" (W. B. Saunders Co.)

Persistent Sore Throat

If a sore throat does not heal in 10 days, take a Wassermann test and look for skin lesions of secondary syphilis.—Handbook for Physicians, Diagnosis of Syphilis, Venereal Diease Education Intitute, Raleigh, N.C.

NEW BOOKS

Any book reviewed or listed in these columns will be procured for our readers if the order, addressed to CLINICAL MEDICINE, 1232-36 Central, Wilmette, Illinois, is accompanied by a check for the published price of the book.



Intestinal Intubation

By Meyer O. Cantor, M.D., Asst. Attndg. Surg., Grace Hospital, Detroit, Mich. Charles C. Thomas, Publ., Springfield, Ill. $7.50.

Surgeons, you can throw away those reprints and notes made on articles by Cantor. In this volume he presents his complete clinical and experimental studies on the decompression of the gastrointestinal colonic tract by means of an indwelling tube. The difficulties experienced in introducing the tubes are explained and proper technic shown; anatomy relevant to the subject is portrayed; complications encountered are described and management described in detail. For medical or surgical management of the paralytic bowel or obstructed bowel, this text is the only complete manual. The author's introduction of a single lumen tube has simplified the withdrawal of heavier materials by aspiration.

Menstruation and Its Disorders

Conference under Auspices of National Committe on Maternal Health. Edited by Earl T. Engle. Charles Thomas, Springfield, Ill. 1950. $7.50.

Here is no superficial or empirical approach to the study of menstruation, rather a detailed, laboratory, histologic and hormonal approach to the problem, by a number of authorities in the field. Every gynecologist must have this book. He will understand the underlying physiopathologic processes only if he does so. Humoral factors related to peripheral vascular homeostasis is especially recommended reading.

Medical Diseases of the Kidney

By J. F. A. McManus, M.D., Associate Professor of Pathology, Medical College of Alabama, Birmingham. 100 illustrations. Lea and Febiger: Philadelphia. 1950. $6.00.

After a brief introduction to the study of the nephron in general and the basic anatomy of the kidney, the author discusses acute and chronic renal failure, chronic pyelonephritis and glomerulosclerosis. The prose is terse and fact filled; the illustrations make up a very useful atlas. The microphotographs are clear, especially of the glomeruli.

Acute Appendicitis and its Complications

By Frederick Fitzherbert Boyce, M.D., Assistant Professor of Clinical Surgery, Tulane University School of Medicine, New Orleans. Senior Visiting Surgeon, Charity Hospital of Louisiana. New York City: Oxford University Press. 1949. $3.75.

Any lesion that kills 5,000 persons yearly is worthy of respect and further study. Reviewers of this book tend to sniff and say that there is no need for further publication on such a well worn subject. The contrary is true.

Acute appendicitis cannot be treated with penicillin and sulfonamide, even though some of its complications may be, as the literature has seemed to indicate. The diagnosis is often difficult and management tedious. Surgical technic is occasionally too much for the interne or surgical resident. Recognition and management of the complications are often taxing even to the most studious surgeon. This book is an excellent guide.

The reviewer feels that the author has quickly jumped over recurrent appendicitis and chronic appendicitis. In many instances, a well taken history will indicate minor attacks preceding the acute onset. The "crippled" appendix that smoulders along is well known to thoughtful pediatricians.

Applied Medicine

By G. E. Beaumont, D.M., F.R.C.P., Physician to Middlesex Hospital and Hospital for Diseases of Chest, Brompton, England. Phila.: Blakiston Co. 1950. $6.00.

A fascinating book and one that may be read for relaxation as well as for medical information. The author well describes his patients in the English manner, with emphasis upon bedside study of the patient. This manner of practice is almost obsolete in the United States, where the postgraduate teacher reaches for the chest x-ray or electrocardiogram before he displays the patient. Good clinical judgment is demonstrated by his management of cases presented. His "Idle Thoughts", a series of penetrating aphorisms at the close of the volume, are true and compress much thought into small capsules.

The Human Venture in Sex, Love and Marriage

By Peter A. Bertocci, Professor of Philosophy, Boston Univedsity. Haddam House; Association Press, N.Y.C. 1949. $2.50.

How can the average person in the teens and twenties *control* sex, not inhibit it? The author shows how easy it is to rationalize our desires, to find excuses for premarital intercourse in the Kinsey Report and in Freud's writings. He expounds a philosophy of life that the average person can understand and find interesting.

Mitchell-Nelson Textbooks of Pediatrics

Edited by Waldo E. Nelson, M.D., Professor of Pediatrics, Temple University School of Medicine, Philadelphia. Fifth Ed. W.B. Saunders and Co. 1950. $12.50.

Sixty-three contributors have made up this masterpiece of pediatric reference. Parenteral fluid therapy has been brought up to date by Katharine Dodd. Histoplasmosis is well presented. Congenital heart disease has been revised by a pediatrician and by the famed pediatric surgeon, Willis J. Potts. Care of the premature infant is a good clinical section. The book cannot be too warmly recommended to general practitioners and pediatricians, also to surgeons who care for pediatric patients.

Human Sex Anatomy

By Robert L. Dickinson, M.D. Second Ed. Williams and Wilkins Co. 1949. $10.00.

Facts instead of fancy; this atlas illustrates and describes anatomy associated with sex, the size of the erect penis, its ejaculate (the author believes that ejaculation is a false term), the distensibility and course of the vagina, the variations in sex anatomy within normal limits and so on. The author is a master artist and a clear thinking gynecologist. He feels that if the physician and the patient understand the structure and function of the sex organs that there will be far fewer cases of dyspareunia, sexual unhappiness, pelvic and other symptoms, and divorce. Every physician and most patients would do well to glance over the hundreds of illustrations.

The Life and Time of Jehudah Halevi

By Rudolf Kayser, New York: Philosophical Library, 1949. $3.75.

The Arabs and Jews intermingled their creative genius in Spain creating an advanced society which stood as a landmark for centuries. Certain of the philosophers and the historians were very great men. This book tells of the stirring story and of Halevi. It is well written and interesting.

Ophthalmic Medicine

By James Hamilton Doggart, M. D., F.R.C.S. (Eng.) Surgeon and Late Research Scholar, Moorfields, Westminster and Central Eye Hospital, Philadelphia: The Blakiston Co. 1949. $8.00.

The author feels that an ophthalmologist is first a physician, then a technician of ocular surgery. He correlates body disease and abnormalities of the various systems, especially endocrine and general medicine, with ophthalmic signs and symptoms. A valuable book for the general physician and for the ophthalmologist to bring them closer together, and benefit the patient.

Fundamental Considerations In Anesthesia

By Charles L. Burstein, M.D., Chief, Department of Anesthesiology, Hospital for Special Surgery, N.Y.C. Attending Consultant in Anesthesia, Veterans Adminstration Hospital, Bronx, N.Y. New York: The Macmillan Co. 1949. $4.00.

The relationship of physiology and anesthetic considerations to clinical employment of anesthetic agents is well portrayed. The prevention of complications and the treatment of complications are discussed, illustrated where possible and made clear in all instances. The technician anesthetist will also learn much from this text, with special regard to such phobias as laryngeal spasm, coeliac reflex and shock.

Bedside Diagnosis

By Charles Mackay Seward, M.D., F.R.C.P. (Edin.) Honorary Physician, Royal Devon and Exeter Hospital and others. Foreword by Sir Henry Cohen. Baltimore: Williams and Wilkins Co. 1949. $3.50.

This is clinical medicine as it confronts the physician who must make a diagnosis. The author takes the primary symptom or sign then unravels its possible causes, in a logical, thoughtprovoking way. The discussion of psychogenic etiologic factors makes the book well balanced.

Urological Surgery

By Austin Ingram Dodson, M.D., F.A.C.S., Professor of Urology, Medical College of Virginia, Richmond, Va. etc. Second Ed. St. Louis: The C. V. Mosby Co. 1950. $13.50.

Every aspect of urologic technic has been described, and in many instances, illustrated admirably by Helen Lorraine. Very practical is the material on urologic diagnosis and urography, which describes and portrays roentgenograms of many interesting and puzzling cases.

This second edition has many splendid contributions by 12 other authorities. All phases of general surgical practice, including pre- and postoperative care, are modernized.

Brucellosis (Undulant Fever)

By Harold J. Harris, M.D., F.A.C.P. New York: Paul B. Hoeber, Inc. Harper and Brothers Medical Book Department. $10.00. 1950.

The general practitioner who wishes to learn about brucellosis would do well to read this book. It is clear, readily understood and not overbalanced in any direction. The author calls attention to the frequency of brucellosis, especially chronic brucellosis, how it may be recognized by the average physician and how it may be treated. Therapy has been brought up to date. Internists will find the bibliography complete and unusual forms of the disease mentioned.

Medicine Could Be Verse

By Charles G. Farnum, M.D. Introduction by Strickland Gillilan. New York City; Exposition Press, $3.00, 1950

Delightful short verse, usually witty, about patients and things that may be wrong with them. The few stanzas concerning the abscessed tooth should become classic. All physicians and many patients will like this general practitioners poetry.